

CASE REPORT FORM

Listeriosis

DiseaseName _____		EpiSurv No. EpiSurvNumber _____	
Disease Name DiseaseName _____			
<input type="radio"/> Listeriosis		<input type="radio"/> Listeriosis - perinatal	
Reporting Authority			
Name of Public Health Officer responsible for case		OfficerName _____	
Notifier Identification			
Reporting source* ReportSrc		<input type="radio"/> General Practitioner	
		<input type="radio"/> Hospital-based Practitioner	
		<input type="radio"/> Laboratory	
		<input type="radio"/> Self-notification	
		<input type="radio"/> Outbreak Investigation	
		<input type="radio"/> Other	
Name of reporting source		ReportName _____	
Organisation		ReportOrganisation _____	
Date reported* ReportDate		Contact phone ReportPhone _____	
Usual GP UsualGP		Practice GPPracticeName	
		GP phone GPPhone _____	
GP/Practice address		Number houzenumber Street streetname Suburb suburb	
		Town/City towncity Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Case Identification			
Name of case* Surname Surname		Given Name(s) GivenName	
NHI number* NHINumber		Email Email _____	
Current address* Number houzenumber Street streetname Suburb suburb			
		Town/City towncity Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Phone (home) PhoneHome		Phone (work) PhoneWork	
		Phone (other) PhoneOther _____	
Case Demography			
Location TA* TA		DHB* DHB _____	
Date of birth* DateOfBirth		OR Age Age <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years AgeUnits	
Sex* Sex		<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Indeterminate <input type="radio"/> Unknown	
Occupation* Occupation _____			
Occupation location occupation_place_type		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name occupation_place_name _____			
Address Number houzenumber Street streetname Suburb suburb			
		Town/City towncity Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Alternative location occupation_place_type		<input type="radio"/> Place of Work <input type="radio"/> School <input type="radio"/> Pre-school	
Name occupation_place_name _____			
Address Number houzenumber Street streetname Suburb suburb			
		Town/City towncity Post Code postcode <input type="checkbox"/> GeoCode geocode addressmatchaccuracy	
Ethnic group case belongs to* (tick all that apply)			
<input type="checkbox"/> NZ European EthNZEuropan		<input type="checkbox"/> Maori EthMaori	
		<input type="checkbox"/> Samoan EthSamoan	
		<input type="checkbox"/> Cook Island Maori EthCookIslandMaori	
<input type="checkbox"/> Niuean EthNiuean		<input type="checkbox"/> Chinese EthChinese	
		<input type="checkbox"/> Indian EthIndian	
		<input type="checkbox"/> Tongan EthTongan	
<input type="checkbox"/> Other (such as Dutch, Japanese, Tokelauan)		*(specify) EthOther EthSpecify1 _____ EthSpecify2 _____	

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Basis of Diagnosis

CLINICAL CRITERIA

Fits Clinical Description* **FitClinDes** Yes No Unknown

Clinical Features*

Perinatal Case*	Non-perinatal Case*
Illness in mother IIIMother <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Meningitis Meningitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Preterm labour Labour <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Septicaemia Septicaemia <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
Illness in infant IIInfant <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Other (specify) OthSymSpec _____
Intrauterine death Death <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	

LABORATORY CRITERIA

Isolation of *Listeria monocytogenes* from a normally sterile site* Yes No Not Done Awaiting Results

Isolation

If yes, specify site:*

Mother MothrSite	<input type="radio"/> blood culture
	<input type="radio"/> high vaginal swab
Foetus/neonate FoetSite	<input type="radio"/> blood culture
	<input type="radio"/> CSF
	<input type="radio"/> body swabs
	<input type="radio"/> placental tissue, foetal tissue
	Other (specify)* FoetSitOther _____
Non-perinatal case NonPSite	<input type="radio"/> blood culture
	<input type="radio"/> CSF
	Other (specify)* NonPSitOther _____

STATUS* **Status** Under investigation Confirmed Not a case

ADDITIONAL LABORATORY DETAILS

Serotype (specify) **Sereotype** _____

Clinical Course and Outcome

Date of onset* **OnsetDt** _____ Approximate **OnsetDtApprox** Unknown **OnsetDtUnknown**

Hospitalised* **Hosp** Yes No Unknown

Date hospitalised* **HospDt** _____ Unknown **HospDtUnknown**

Hospital* **HospName** _____

Died* **Died** Yes No Unknown

Date died* **DiedDt** _____ Unknown

Was this disease the primary cause of death?* **DiedPrimary** Yes No Unknown

If no, specify the primary cause of death* **DiedOther** _____

Outbreak Details

Is this case part of an outbreak (i.e. known to be linked to one or more other cases of the same disease)?*

Yes **Outbrk** If yes, specify Outbreak No.* **OutbrkNo** _____

Risk Factors**PERINATAL CASES****Pregnancy details**Due date* **DueDate** _____ Unknown **DueDateUnknown**Date of delivery* **DelivDate** _____ Unknown **DelivDateUnknown**Gestation at date of delivery* **GestationWk** _____ weeksFoetus/infant died* **InfanDied** Yes No UnknownDate died* **InfDthDate** _____ Unknown **InfDthDateUnknown**If foetus/infant died from disease other than listeriosis, specify* **InfDthSpec** _____**NON-PERINATAL CASES****Underlying illness*** **UndIllness** Yes No UnknownIf yes, specify* **UndIllSpec** _____**Receiving immunosuppressive drugs*** **ImmunoDrugs** Yes No UnknownIf yes, specify* **ImmunoDSpec** _____**Admitted to hospital for treatment of another illness (other than listeriosis)*** **HospTrtment** Yes No UnknownIf yes, specify* **HospTrtSpec** _____**ALL CASES****Was case overseas during incubation period (range = 3-70 days) for listeriosis?*****Overseas** Yes No Unknown**Other risk factors for listeriosis, specify*** **RiskOthSpecify****Source****Was a source *confirmed* by*****a) Epidemiological evidence*** **SceConfEpi** Yes No Unknown

e.g. part of an identified common source outbreak (also record in outbreak section) or person to person contact with a known case

b) Laboratory evidence* **SceConfLab** Yes No Unknown

e.g. organism or toxin of same type identified if food or drink consumed by case

Specify confirmed source(s)* From consumption of contaminated food or drink, specify food or drink **ConfFD**_____ **ConfFDName** _____ **ConfFDSpec** From contact with infected animal, specify type of animal **ConfInfAnim** _____ **ConfInfAnimSpec** Person to person contact with another case, specify case **ConfPPSpec** _____ **ConfPPSpec** From other confirmed source, specify source **ConfOtherSce**_____ **ConfOtherSceSpec**

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Source continued

If not, was a *probable* source identified? * **SceProb**

Yes

No

Unknown

Specify *probable* source(s) *

From consumption of contaminated food or drink, specify food or drink **ProbFD**

_____ **ProbFDName** _____ **ProbFDSpec**

From contact with infected animal, specify type of animal **ProbInfAnim**

_____ **ProbInfAnimSpec**

Person to person contact with another case, specify relationship **ProbPP**

ProbPPSpec

From other probable source, specify source **ProbOtherSce**

_____ **ProbOtherSceSpec**

Management

CASE MANAGEMENT **Excluded**

Case excluded from work or school / pre-school / childcare until well?

Yes

No

NA

Unknown

Comments*

Comments